MISSISSIPPI STATE DEPARTMENT OF HEALTH
Strategic National Stockpile (SNS) and Pandemic Influenza Programs
Provider Enrollment

□ SNS Program □ Pandemic Influenza Program (Treatment Center Use) □ Both

□ Initial Enrollment □ Renewal

Facility _____

Address _____
Street *City* *State* *Zip Code* *County*

Telephone ___(_____)_____ Fax ___(_____)_____

1. Facility Contact's Name _____
Last *First*
Phone: _____E-Mail _____

2. Facility Contact's Name _____
Last *First*
Phone: _____E-Mail:_____

Facility's Medical Provider Number (if applicable)_____

Coordinating Physician's Name: _____Medical License _____

To participate in the SNS Program and/or the Pandemic Influenza Program and receive, free of cost, Federal Strategic National Stockpile antibiotics, vaccine and medical supplies through the Mississippi State Department of Health, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this hospital, nursing home, medical office, group practice, managed care organization, community/migrant/rural clinic, health department, other health delivery facility, detention facility, mental health facility, prison, home health agency, or business of which I am the **[please circle] CEO, Business Manager, Minister, or physician-in-chief or equivalent:**

I agree to provide the MSDH with the number of staff and clients to receive medication and/or vaccine; this information will be updated annually upon renewal of Provider Enrollment.

1. I agree to have a coordinating physician who will oversee the dispensing of medications and/or administration of vaccine. The physician does not have to be on-site, but staff will work under his/her direction.
2. The facility will follow the same treatment algorithms as used in the standing orders for the state.
3. A representative from the facility, with proper identification, will pick up medications, vaccines, and/or supplies for clients and staff from the pre-designated Point-of-Dispensing (POD) site. The facility will provide MSDH with the name of the representative designated to pick up medications and/or vaccine prior to pick up.
4. Upon arrival to the designated POD site, the representative will present two personal ID's, one issued by the facility, and a picture ID issued by the state.
5. The representative will sign for all medications, vaccines and/or supplies received.
6. The facility will notify MSDH when the supplies reach the facility and if there are any discrepancies between the order and delivery.
7. The facility will be responsible for administration of the medication/vaccine, distribution of information sheets, and collection of completed health information forms. Health information forms will be returned to MSDH within 48 hours for patient tracking.
8. The facility agrees to make no charge for the medication/vaccine or for any of the services provided as a part of the administration of the medication/vaccine.
9. For the purpose of State and/or Federal Laws and regulations, I will:
    a. Maintain and make available all records to the Mississippi State Department of Health, the U.S. Department of Health and Human Services, and/or their assignees or agents;
    b. Comply with Presidential Executive Order No. 12549, Certification Concerning Debarment and Suspension.
10. The State may terminate this agreement at any time for failure to comply with these requirements and I may terminate this agreement at any time for personal reasons.

_____

Signature of Administrative Representative for Facility Date

_____

Signature of Coordinating Physician Date

This record is to be submitted to and kept on file at the Mississippi State Department of Health, and must be updated in accordance with State policy.

staff/employees/faculty _____

staff/employee/faculty's family members _____

patient beds _____

enrolled students _____

enrolled student's family members _____

TOTAL Number of persons needing medications/vaccinations _____

For State Use Only Section:

Date Certified for SNS ___ ___ / ___ ___ / _____
Month Day Year

Date Certified for Pandemic Influenza ___ ___ / ___ ___ / _____
Month Day Year

Person Approving Application

_____
Print

_____
Signature

Original Copy to be kept on file at MSDH District Office by Dist. Surveillance Nurse
Copy to be sent to SNS Program at MSDH Central Office
Copy to be given to Facility